Pamela A Nicoara DDS MSD PLLC
PERIODONTOLOGY • IMPLANTOLOGY • ORAL MEDICINE

Health History

Name: _____ Date: _____ Age: _____ Height: _____ Weight: _____ Gender: M ☐ F ☐

1. Are you under the care of a physician for any reason? Y ☐ ***N*** ☐ Reason: _____
2. When was your last physical exam with your physician? _____ If a woman, are you pregnant? Y ☐ Due date? _____
3. Do you need antibiotics prior to receiving dental care? Y ☐ ***N*** ☐ Reason: _____
4. Please list any major hospitalizations, surgeries and blood transfusions starting with most recent:

Date	Reason	Leave Blank for Doctors Notes

5. Do you have, or have you ever had, any of the following conditions?

Any type of heart disease	Y ☐ ***N*** ☐	Diabetes	Y ☐ ***N*** ☐	Tumor ☐ or Cancer ☐	***N*** ☐
Heart attack	Y ☐ ***N*** ☐	-List year diagnosed		-List type	
-List year of attack		-List last HbA1c value		-List year diagnosed	
Angina (chest pain)	Y ☐ ***N*** ☐	-List last HbA1c date taken		Radiation treatment	Y ☐ ***N*** ☐
Pacemaker	Y ☐ ***N*** ☐	Kidney disease	Y ☐ ***N*** ☐	-List area treated	
-List year placed		-List year diagnosed		-List year of treatment	
Artificial heart prosthesis	Y ☐ ***N*** ☐	Hepatitis ☐ or Liver disease ☐	***N*** ☐	Leukemia ☐ or Lymphoma ☐	***N*** ☐
-List year placed		-List type of disease		-List type	
High blood pressure	Y ☐ ***N*** ☐	-List year diagnosed		-List year diagnosed	
High cholesterol	Y ☐ ***N*** ☐	Viral infections	Y ☐ ***N*** ☐	Osteoporosis	Y ☐ ***N*** ☐
Stroke	Y ☐ ***N*** ☐	-List type of infection		-List year diagnosed	
-List year of event		-List year diagnosed		Artificial joint	Y ☐ ***N*** ☐
Anemia ☐ or other blood disorder ☐	***N*** ☐	Cold sores/Mouth sores	Y ☐ ***N*** ☐	-List year of replacement	
Prolonged bleeding	Y ☐ ***N*** ☐	-List frequency of sores		-List joint (s)	
Bruise easily	Y ☐ ***N*** ☐	HIV ☐ or AIDS ☐	***N*** ☐	Epilepsy ☐ fainting ☐ seizures ☐	***N*** ☐
Stomach ☐ or Duodenal ☐ ulcer	***N*** ☐	-List year diagnosed		-List date of last episode	
-List year of diagnosis		Rheumatoid arthritis	Y ☐ ***N*** ☐	Sinus Problems	Y ☐ ***N*** ☐
Reflux, heartburn, indigestion	Y ☐ ***N*** ☐	-List year diagnosed		Asthma	Y ☐ ***N*** ☐
Irritable bowel ☐ or Colitis ☐	***N*** ☐	Lupus ☐ or Sjogren's ☐	***N*** ☐	-List year diagnosed	
-List year diagnosed		-List year diagnosed		Bronchitis ☐ or Emphysema ☐	***N*** ☐
Skin disease	Y ☐ ***N*** ☐	Immunosuppresive disease	Y ☐ ***N*** ☐	-List year diagnosed	
-List type		-List disease type		Mouth breather ☐ or Snore ☐	***N*** ☐
-List year diagnosed		-List year diagnosed			
Depression ☐ or Mental illness ☐	***N*** ☐	Thyroid ☐ or Parathyroid ☐ issue	***N*** ☐	Tuberculosis	Y ☐ ***N*** ☐
-List year diagnosed		-List year diagnosed		Glaucoma	Y ☐ ***N*** ☐

6. Are there any other conditions you have that are not listed above? _____
7. Do you currently ☐ or have you ever ☐ smoked ☐ or chewed ☐ tobacco? ***N*** ☐ a. How many packs/cans per day? _____
   b. For how many years? _____ c. When did you quit? _____ d. Where in the mouth do you keep the chew? _____
8. Have you ever tried to quit? Y ☐ ***N*** ☐ a. Using which methods? _____ b. Are you interested in quitting? Y ☐ ***N*** ☐
9. Do you currently have ☐ or have you ever had ☐ an alcohol ☐ or drug ☐ addiction? ***N*** ☐ Explain: _____
10. Please list any medications (prescription or over the counter) you are taking: Check here if not taking any medications ☐

Name	For what condition	Dosage	Year Started

11. Have you ever taken Bisphosphonates like Fosamax ☐, Reclast ☐, Actonel ☐, Boniva ☐, Aredia ☐, Zometa ☐, or Prolia ☐? ***N*** ☐
    a. How long ago did you stop? _____ b. For how long did you take it? _____

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12. Please list any allergic or adverse reactions to any drugs (novocaines, penicillin, sulfa, etc)? Check here if no known allergies ☐

Drug	Type of reaction	Leave Blank for Doctors Notes

Dental History

Chief Complaint:

1. What is your reason for coming in today? _____
2. How long has this been an issue? _____ What treatments have you had for this? _____
3. Are you currently in pain? Y ☐ ***N*** ☐ Explain: _____
4. Whom may we thank for your referral to us? _____

Personal History:

5. What is your dentist's name? _____ How long have you been a patient there? _____
6. Have you had regular dental care? Y ☐ ***N*** ☐ When was your last visit to the dentist? _____
7. How often do you get cleanings from the dentist? _____ How long ago was your last dental cleaning? _____
8. Are you fearful of dental treatment? Y ☐ ***N*** ☐ Explain: _____
9. Have you ever had trouble getting numb / had reactions to local anesthetic? Y ☐ ***N*** ☐ Describe? _____

Periodontal History:

10. When was your last deep cleaning with numbing? _____ a. Was it for the whole mouth ☐, or which part? _____
11. Have you ever been told you have periodontitis? Y ☐ ***N*** ☐ When? _____
12. How often do you brush your teeth? _____ a. Is your toothbrush manual ☐, or powered ☐ ?
    b. If powered, which brand? _____ c. How long have you used it? _____
    d. What kind of toothpaste do you use? _____
13. How often do you floss? _____ a. Do you floss the whole mouth ☐ or which part? _____
    b. Do you use other cleaning aids such as proxybrush ☐, Waterpik ☐, or other: _____
    c. How often do you use these other aids? _____ d. How long have you used these other cleaning aids? _____
    e. Do you use them in the whole mouth ☐, or which part? _____
14. Which brand of mouth rinse do you use? _____ b. How often? _____ c. Since when? _____
15. Do you have daytime dry mouth? Y ☐ ***N*** ☐ a. Which cause? _____ b. How treated? _____
16. Have you had cavities in the past 3 years? Y ☐ ***N*** ☐ b. Besides fillings, any fluoride ☐ or dietary changes ☐ implemented?

Jaw and Bite:

17. Do you clench ☐ or grind ☐ your teeth during the day ☐ or at night ☐? ***N*** ☐ a. If at night, do you know you do because:
    a. Your dentist told you ☐, b. Your teeth ☐ or jaws ☐ are sore in the morning, c. Other _____
18. Do you wear a bite guard during the day ☐ or at night ☐? ***N*** ☐ b. How often? _____
    c. Is the guard from your dentist ☐, or the grocery store ☐? d. How long have you used it? _____
19. Do you wear a sleep appliance ☐ or CPAP on your nose ☐ or whole mouth ☐? ***N*** ☐ a. What year did you start? _____
    b. How often do you use it? _____ c. Have you ever had a sleep study? Y ☐ ***N*** ☐ When? _____
20. Do you have problems with your jaw joints: ***N*** ☐, pain ☐, sounds ☐, limited opening ☐, locking ☐, popping ☐, headaches ☐
    a. Which joints? Right ☐, Left ☐ b. How often do you have the joint problems? _____
    c. Have you seen a TMJ specialist in the past? Y ☐ ***N*** ☐ d. Who did you see and when? _____
21. Have your teeth changed in the past 5 years: ***N*** ☐, become shorter ☐, worn ☐, broken ☐, cracked ☐, crowded ☐, spaced ☐
22. Have you ever had orthodontics (braces)? Y ☐ ***N*** ☐ a. Who was/is your orthodontist: _____
    b. When did ☐ or When will ☐ you complete treatment? _____

Your Thoughts:

Are there any other comments or questions you have? _____

_____

_____

By signing below, I acknowledge that I filled out this form to the best of my knowledge, and that I am the person that filled out this form.

Patient signature: _____ Date: _____

Dr. Nicoara's Signature: _____ Date: _____